

## **Traumatic Stress Personality Disorder (TrSPD), Part III: Mental/Physical Trauma Representations—From Focus on PTSD Symptoms to Inquiry into *Who* the Victim Has Now Become**

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*Many trauma patients are unwittingly led to believe that once their traumatic memory, dreams, irritability, sleep disorder, and intrusive ideation are under greater control that the work of integration is complete. The point of view here is that victims' biopsychobehavioral trauma symptoms contain the nucleus of a damaged identity system that distorts the self-image and relational functioning. This nucleus is linked to a dissociated representational memory system. It is this memory system which is implicated in some incest survivors' profoundly negative self-perception, as seen in the assertion, "I am a tragic, soul-destroyer: look at what I've become!" Or in a veteran's belief that "I am the Devil for what happened in combat." One crime victim described his dissociated identifications and emotional volatility in terms of a Dr. Jekyll/Mr. Hyde tendency. Cyclical relational pathology seen so pervasively in the lives of victims are related to these self- and other-representational distortions. Though cognitive and behavioral techniques address the narrative trauma memory system and ameliorate associated distress, these may be less useful in integrating the patient's representational memory system. This article argues that in order to foster post-traumatic integration, the representational memory system may require specialized direct therapeutic action, a focus on mutual relational dynamics between patient and therapist.*

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"Abuser and failed protector self-representations [in incest, rape, and other victim/survivors] ... become activated ... as a consequence of shifts in defensive operations" (Brown, Schefflin, & Hammond, 1998, p. 490).

"The key diagnostic issue is the disturbance in self-structure rather than the manifest symptomatology" (Allen, 1995, p. 49).

## VICTIMS' SHATTERED SENSE OF AGENCY: THE REPRESENTATIONAL PERSPECTIVE

### Beyond the Traumagenic Agent and Dissociated Symptoms

Some therapists are recognizing that when symptoms become the sole focus of traumatherapy that the patient is reduced to a bundle of pathogenic agents, dissociated memories, and incapacitating symptomatology. Many are also becoming aware of the complicated fabric of biopsychological trauma. Many are moving beyond the contents of the victim's verbal accounts to *how* the patient talks (Shapiro, 1996). How the patient talks is related to whom he or she has become as a consequence of having experienced a psychologically toxic, non-metabolizeable event. Relational factors are exceedingly critical to outcome in any therapy (Blatt, et al., 1996; Karasu, 1990. Schaap et al., 1993).

In Part II this writer spoke of the importance of recognizing the victim's *representational world* in trauma assessment, and of the necessity for clinicians to employ diverse assessments instruments that combine projective instruments, projective procedures (e.g., unstructured interview), clinician-administered interviews, and self-report tests that measure *both* narrative traumatic memory and representational memory systems. Despite chronic criticisms against the Rorschach, a strong argument along the lines of Meyer and Handler (1997) has gained some recognition. They wrote, "We are not aware of any other personality scale that uniformly demonstrates such high predictive validity" (p. 1). The proposed combined instrumentation would give the clinician the "mass diagnostic indicators" (Rapaport, Gill, & Schafer, 1968) deemed essential to achieve comprehensive assessment outcome.

The current article focuses exclusively on the victim's representational world, a world of trauma-determined cognitions, memories, perceptions, controls, impulses, and defenses. The article views the victim's representational memory system as connected to personality trauma dynamics, which, like personality dynamics in general, "can only express itself in the language it has learned" (Shapiro, 1996, p. 12). For even though the patient may have resolved the "assaultive power" of intrusive images and affects,

the *dissociated, cyclical relational tendency* remain a pressing problem for victims inside and outside of traumatherapy.

Therapy depends on the patient's verbal accounts about what happened, in addition to the emotional, symptomatic, and behavioral sequelae. Unfortunately, too many therapists see the central therapeutic work as memory processing and symptom management. This is in contrast to the inclusive focus espoused in this article where memory processing/symptom management *and* nuclear personality representational memory system are recognized.

### TRAUMATICALLY ALTERED SELF- AND OTHER-REPRESENTATIONS: MALIGNANT AND BENEVOLENT STRUCTURES

Clinical observations of the effects of trauma and dissociation on the functioning of individuals convincingly show that victims' personality is not a fixed entity. Personality is not immutable (Shatan, 1977): it is influenced, shaped, and structuralized by internal and external forces at *all* points in the developmental life-cycle process. Shapiro (1996) reported that psychologist Jean Piaget had complained that traditional personality theory was not developmental enough, and that it was "*too much a science of the permanent*" (Quoted in Shapiro, 1996, p. 12, italics).

The traumatic stress personality disorder (TrSPD) concept recognizes that personality is transactional and developmental, and is never truly static and permanent. This position naturally creates some real problems for personality theorists who see personality as an *absolutely* permanent structure rather than a *relatively* permanent organization. Personality may be said to be stable over time providing its biological integrity is not unduly challenged by untoward, catastrophic occurrences. Thus, the key diagnostic issue in psychological testing and treatment is "the disturbance in self-structure rather than the manifest symptomatology" (Allen, 1995, p. 49). Discovering this disturbance may require an integrated assessment process that employs projective and non-projective tests (Appelbaum, 1995; Parson, 1997).

In TrSPD, the patient's representational system is shattered into fragments of dissociated cognitions, affects, and behavior. Phenomenologically, an overwhelming event may be experienced as a rapid assault to the victim's self structure, producing a rapid personality *snapping* described by Flo Conway in her new book on cult indoctrination processes. The subjective experience of the victim confronts a pervasive sense of a "shattered self" (Ulman & Brothers, 1989) with the persistent identity of an "endangered

self” (A. Reich, 1960). This sense of being in perpetual danger—from inside, in terms of cognitive, kinesthetic and proprioceptive remembering, and from outside, in terms of sensory/perceptual triggers—reflect some of the widely recognized differences in personality functioning between traumatized and nontraumatized individuals. Horowitz’ decades of theory-building in the area of traumatic stress syndromes led him to conclude that personality factors are inextricably linked to the unique patterns characteristic of trauma pathology. He used Kohut’s theory on narcissistic personality disorder to explain response patterns in patients engaged in short-term traumatherapy (Ulman & Brothers, 1989).

As noted before in the two previous articles, TrSPD is a continuous, transactional (PTSD  $\leftrightarrow$  PD), dissociogenic syndrome in which the *classical signs and symptoms of the traumatic neurosis* and personality disorder traits with disturbed representational sequelae commingle to form a new organization, an irreducible structure. Specifically, TrSPD, as a complex Axis I/Axis II biopsychobehavioral stress disorder, includes the symptoms of PTSD, terror of death, neurobiological hypersensitivity, somatic symptoms, memory deficits, identity fragmentation, meaning insufficiency, amnesia, and attachment dysfunction, and trauma-shattered representational system. Post-traumatic representational phenomena are determined through formal and informal assessments, and through ongoing explorations in trauma psychotherapy.

TrSPD is a concept that involves personality factors and associated representations. The concept is supported by persuasive arguments like Kudler’s (1993), who stated that the “usual division between axes I and II may not apply to the character pathology that follows psychological trauma” (p. 1906, italics added). Additionally, as mentioned in a previous part of this contribution (Part I), the concept of comorbidity in the context of trauma is a problematic one. Deering et al.’s (1996) review of the scientific literature on PTSD comorbid disorders like depression, generalized anxiety, somatization, psychotic, and personality disorders led to the conclusion that so-called “comorbidities” did not meet the strict criteria outlined by Feinstein, and were therefore “not truly comorbid, but ... *interwoven* with the PTSD” (p. 336, italic added). TrSPD is an attempt to call attention to this artificial “division” and to hopefully begin a more meaningful dialogue on the importance a *broadened spectrum* of clinical interests that offer data for therapeutic approaches that engage the total self functioning of the patient. Scientific studies are needed to further elucidate the true nature of PTSD-PD transactions.

Assessment in TrSPD requires exploration of three forms of memory systems: *autobiographical memory*, *narrative traumatic memory*, and *representational memory*. Narrative traumatic memory, a dimension of autobio-

graphical memory, is characterized by fragmented and incomplete memories (Brown, Schefflin, & Hammond, 1998; Parson, 1984). Generally, autobiographical and flashbulb memories are two types of personal memories, the former reflecting memories based on *actual* events experienced by the victim, while the latter is based on events *heard about* at some time (Brown, Schefflin, & Hammond, 1998, Bohannon, 1988).

Narrative traumatic memory differs from normal autobiographical memory in that the former is state-dependent, often delayed, has forgotten aspects, and reflects not just verbal memory, but memory linked to dissociative, behavioral, somatic, proprioceptive, kinesthetic, dysphoric, olfactory, and visual elements. Narrative memory is accompanied by what Janet called "vehement emotions", and features vividness and freshness of imagery and emotion. Traumatic memory is encoded differently due to a variety of complex biopsychobehavioral factors (Brown, Schefflin, & Hammond, 1998; Parson, 1984). Consistent with this view is Chu et al.'s (1996) observation that traumatic memory is associated with neurological and cognitive features that are quite different than ordinary memory.

In trauma, narrative memory and representational memory are both shaped by the overwhelming event, both are processed in trauma treatment, and both are to be integrated into the conscious autobiographical memory. Both are measured in psychological assessment, and both have an insufficiency of integration. Trauma psychotherapy employs procedures geared to increase mastery and integration of *both* memory systems, the latter being facilitated chiefly by therapeutic relational variables (e.g., transference and countertransference). Narrative memory integration is viewed as a prerequisite therapeutic achievement to representational memory processing and integration. Excising the demons of traumatic memory does not automatically ameliorate trauma-bedeveled interpersonal relationships. For, as Davies and Frawley (1994) put it, "traumatic memories can be abreacted but abusive relationships [i.e., representational abuse memories] cannot be so easily excised" (p. 214).

Integration refers to the *psychological re-unification* of split-off, dissociated aspects of the personality (Parson, 1984, 1994a, 1994b). Brown, Schefflin, and Hammond (1998) view integration as comprising two varieties of memory work in phase-oriented traumatherapy: (1) integration of previously dissociated aspects of the personality or reversal of primary dissociation; and (2) the gradual processing of all relevant aspects of the personality, or reversal of secondary dissociation (p. 449). There is now wide consensus that mere abreaction is insufficient to achieve integration after trauma (Parson, 1984). Steele (1989) and Brown, Schefflin, and Hammond (1998) are thus correct that in order for abreaction to be helpful to

the patient, catharsis must be linked to cognitive restructuring, and to integration of the representational system.

### Representational Memory

Brown, Schefflin, and Hammond (1998) review the controversy over representational memory in their book, *Memory, Trauma Treatment, and the Law*, and highlight the key issues in the debate. Is representational memory trace memory, that is, directly connected to an actual original stimulus? Or, is representational memory constructed by the person's active mental organizing capabilities. The authors summarize the essential issues in representational memory research:

(1) relative accuracy versus relative inaccuracy in the memory representation as it corresponds to the original stimulus event; (2) highly specific versus general memory representation, and (3) subject as passive recipient who records an exact copy of the event versus subject as active reconstructor of memory representations (Brown, Schefflin, & Hammond, 1998, p. 69).

It is unclear which of these two perspectives—the trace or constructed memory—is the most valid at the present time. There are proponents for both positions. In the present context of traumatic stress, this writer believes that both trace and construction may be applied to various traumatically organized memories systems until more definitive scientific developments are found.

Most psychological trauma assessments reported in the literature focus exclusively on victims' narrative trauma memory contents and associated emotions (measured chiefly by self-reports instruments and the "symptoms-counting orientation"), but not on the representational significance of the symptoms. Using the victim's symptoms may offer insights into the unconscious meaning of the trauma and representational systems.

The traumatic representational memory system *consists of all internalizations that occurred under the impact of intense fear and terror, and/or expressed aggression*. These are also connected to pre-traumatic representational configurations which are also assessed and addressed in the treatment. Among the most salient malignant representations are *violent betrayer*, and its relational opposite, *ineffectual authority*. Several writers have discussed the problem of dissociated representational phenomena victims endure (Brende & Parson, 1985; Brown, Schefflin, & Hammond, 1998; Parson, 1984, 1985a, 1994a). Negative representational phenomena have been referred to as "internalized abuser" (Brown & Fromm, 1986) in cases child physical and sexual abuse, "aggressor" with killer-self identifications (Brende & Parson, 1985) in war veterans, "internalized offender" (Salter, 1995) in victims of sexual vic-

timization, and the “gang banger introject” in inner city multiply violence-traumatized children (Parson, 1994a).

*Differentiating TrSPD from Most DSM-I V Personality Disorders:  
Implications for Shaping the Representational Structures*

The salient features of TrSPD may be differentiated from some traditional personality disorders, though significant overlap is inevitable. Here is a preliminary attempt to delineate some differentiating responses between TrSPD and personality disorders. These features of traumatic stress shape the victim's representations.

*Persistent Nightmares as Traumatic Marker.* Persistent nightmares are traumatic markers for TrSPD. In the nontrauma context, Freud referred to dreams as the “royal road to the unconscious.” In the trauma context, however, it is the traumatic anxiety dream (or nightmare) that represents the *royal road to the traumatic experience* with intrinsic guide to representations and resolution (Parson, 1984; 1988a, 1988b). The images and contents of these dreams show core dissociative processes contained in the victim's psyche, some, and behavior. This dreaming intensity of stirred-up affectivity offers the clinician a window of opportunity through which to witness what really happened, and to grasp the true nature of etiologic, meaning, and representational variables.

*Changes in Attention or Consciousness.* Post-traumatic changes in the victim's personality after severe exposure (Weine et al., 1998) is accompanied by a disturbance in consciousness. These changes are also seen clinically in the victim's amnesic symptoms, dissociative responses, and automatic reliving.

*Changes in Meaning System.* As post-traumatic sequelae, the victim experiences deficits in the capacity to formulate a personally coherent explanatory model for the trauma and for subsequent trauma responses.

*Failure to Consummate Action.* Contributing further to the understanding of the traumatic personality, Kardiner (1941) saw post-traumatic nightmares as “the most universal earmark of the traumatic syndrome.” He found that “these constant dreams of the failure to consummate successful actions are, in fact, the key to the pathology” (Kardiner, 1941, p. 249, italics added). This persistent “failure to consummate successful actions” is one of personality organization (and not merely one of symptomatic expression), and is generally associated with the perceived deficits in control of unbearable affects, and with declivity in motivation, confidence, morale, and sense of safety. These experiences and responses (amnesia,

failure of completion, absence of a sense of purpose, and the “treadmill” sense of existence) collectively frame the sense of *persistent stasis*.

*Narcissistic Rage Over Perceived Deficits in Post-Trauma Competence.* This is an affective response of the narcissistically injured self. The painful awareness of having a serious disability in self-regulation constitute a narcissistic injury. This injury is associated with intense feelings organized around psychological defenses to preserve the sense of self, and restore central organizing beliefs (about one’s competence, control, and personal worthiness). This writer’s experience shows that the traumatized person’s obsession with self is a manifestation of narcissistic counter-disintegrative defenses that serve survival and self image-preserving ends. The patients appearing in the case vignettes below all experienced a reduced capacity to tolerate psychophysiological arousal. They were also painfully aware of deficits in the balance between stimulation/arousal and soothing, an experience shaping the representational sense of *narcissistic chagrin*.

*Affective Stress Response.* Affective stress response is seen in victims’ experience of intense guilt, shame, rage, depression, irritability, moral anxiety, death anxiety, and self-abusing impulses and behaviors (Parson, 1994a, 1994b).

*Persistent Psychological Deadness.* Persons surviving traumatic violence often exhibit characterological apathetic indifference, and a numbing demeanor with blunting of emotions. They also show a constricted range of affects from mild to extreme variants of what Nietherland (1968) referred to as the robotlike numbness and puppetlike demeanor in Holocaust survivors, and Shatan (1974) described as the persistent feeling of being “frozen into stone like gargoyles” (p. 9) in Vietnam war veterans.

Alterations in the victim’s personality functioning often produce a profound intolerance for strong affects, like emotional shock, rage, anger, terror, guilt, explosive temper, as well as intimacy, and feelings of love and tenderness. As an aspect of affective deadness, the victim experiences a sense of *affect incompetence*, in which a confluence of powerful feelings remain chaotic and disorganizing. This condition is akin to Eigen’s (1996) “psychic deadness,” a state of emotional coldness that is immune to good experiences in one’s life.

*Disturbed Capacity to Modulate Hyperarousal and Aggression.* Poor tolerance for strong affects, and ineffectual regulatory controls over consciousness, are central problems victims endure after trauma. This impaired ability to modulate emotions is accompanied by persistent irritability, sleeplessness, and explosive anger and rage, and sense of *arousal incompetence*.

*Dilemma of Memory.* The person also experiences memory as a source of persistent torment. The “dilemma of memory” is characterized by a fear of remembering, terror of not being able to forget, and an inability to recall



important personal data. Problematic memory systems, a core dimension of the traumatized self, combined with the inner sense of mental confusion (generated by unstable affectivity and modulation deficits), form the “turbulent/unfocused self.” Each victim/survivor presented below had this representation prominently identified in their clinical presentation.

*Anxiety-Reactivation Tendency Linked to Intrapsychic and Environmental Triggers.* Traumatized persons suffer more anxiety, pessimism, emotional blunting and anhedonia than non-traumatized individuals. Brown, Schefflin, & Hammond (1998) note that “triggers” are of two general types: *state-dependent* and *context-dependent*. The latter type occurs as a consequence of direct exposure to what van der Hart and Nijenhuis called “stimulus-driven reactivation,” environmental stimuli that pressure the victim to psycho-physiological arousal and to reliving various elements of the trauma. The former type of trigger is based upon state changes, identified as “(1) non-specific physiological arousal; (2) emotional arousal unrelated to the original trauma; (3) emotional arousal associated with the original trauma; (4) exposure to subsequent traumatic events/arousal; and (5) normal, phase-specific developmental changes...” (Brown, Schefflin, & Hammond, 1998, p. 439).

*Hypervigilance to the Environment.* Abraham Kardiner (1941) found significant personality changes in trauma victims, and identified a defensive “enduring vigilance for and sensitivity to environmental threat” (p. 38).

*Somatic Memory and Symptoms.* Though many psychiatric disorders have somatic components, in traumatic stress environmental “triggers” precipitate anxiety, while mobilizing avoidance defenses. Symptoms include digestive system distress, chronic pain, gastrointestinal pathology, cardiopulmonary stress responses, conversion symptoms, and sexual dysfunctions.

*Persistent Avoidance.* In traumatic stress conditions the individual tends to avoid activities, places, and people that would provoke sudden unbidden ideation, and physiological arousal.

*Loss of Normal Illusion.* After trauma, the victim is plunged into a painful realization that “routine, automatic, secure, [and] self-confident activity” (Becker, 1973, p. 26) are no longer possible. The sense of personal invulnerability, competence, personal control, and worthiness are also casualties of psychological trauma.

*Persistent Fear of Losing Control.* Intrapsychic and biological (state-dependent) and environmental (context-dependent) stimuli are constant sources of response-provoking stress and tensions. The ominous sense of losing control over aggressive and sexual impulses, and over control of physiological and body functions is a constant stressful state experienced by victims. The subjective sense of losing control is unconsciously associated with death. Thus, death anxiety is usually linked to fears of loss of control.

*Enduring Fear Structures.* Trauma victims often report a deficient capacity to modulate anxiety, aggression, hyperarousal, and the post-traumatic sense of vulnerability (Van der Kolk, 1987; Parson, 1984, 1994a 1996).

*Loss of the Sense of Safety.* The sense of never feeling comfortable and safe appears to be one of the cardinal features of traumatic stress responses and disorders. Being forced to deal in their daily lives with environmental triggers, hypervigilant functioning, physiological symptoms, fear-based avoidance, the incapacity for illusion, control deficits, and need for safety, the victim/survivors featured in the clinical vignettes relates to the pervasive problem most traumatized persons experience; namely, the sense of *ubiquitous endangerment*.

*Severe Identity Disturbance.* The victim often struggles to find a way to reconcile the new, trauma-acquired identity with the old identity. Identity is perhaps the first casualty of overwhelming experiences. Erik Erikson (1968) was aware of this and so concluded in his observations of World War II veterans that they had lost a sense of ego-identity, or self-sameness and continuity. Since identity problems were noted as a primary regulatory deficit of the personality among the patients in the case studies, therapy dealt with issues around identity fragmentation, linked to disturbances in consciousness, memory, feelings, thought, and perception—the “shattered self” representation.

### Clinical Vignettes

Three brief case studies of TrSPD are presented to demonstrate the issue of representations in traumatherapy. Most of the responses above were reported by these patients. One patient is a victim of urban community violence, another suffers the aftermath of early rape trauma, while the third patient came to therapy after a life-threatening and fatal motor vehicular accident.

#### *Case of Urban Violence Traumatic Stress*

Ms. O. is a 23-year-old woman who endured a traumatic slashing by a violent man brandishing “a huge knife during daylight in the street.” The man had followed her out of a restaurant headed to her car on the way to meet her fiancé. While at the door of the restaurant about to leave, the man had approached her claiming she looked like someone he once knew. She had politely told him that she was not the person he thought she was, and then left the restaurant. After a period of 10 minutes of walking down the sidewalk of this eastern city, Ms. O. heard the “blood curdling” voice of madness and rage. She looked around to find that the same man she had left behind at the restaurant was coming “straight for me,” as his voice reverberated with a bawling, barking, howling, and roaring menace mixed with

barely discernible expletives and obscenities. The man chased her for several feet, and lunged toward her with a 12 inch knife, violently moving his arms left to right, from right to left. The knife made contact and viciously cut her as she tried to get away from the assailant. The ambulance took her to the hospital bleeding profusely where she had to receive dozens of stitches. Several permanent scars were left on her face. "I almost bled to death," she recollects. The assailant had slashed the patient's face, chest, right shoulder, neck, and right hand, partially severing her index finger. This incident occurred five years ago: the physical wounds have healed with permanent scars and disability; but the emotional wounds have been enduring.

According to Ms. O. there was no psychiatric family history in her background, describing her family life as "average, loving, and peaceful." Her father was a local politician; her mother a well-known educator. Her early developmental history was reportedly uneventful, her school life had been remarkable and successful (on the Dean's List consistently), and no evidence of personal psychopathology was noted.

Ms. O's presenting complaints included persistent nightmares since the event, as well as persistent fears, "rage attacks," anxiety, depression, dissociative symptoms, shame, low self-esteem, and "somatic reliving" symptoms pertaining to the areas of her body that were slashed by the assailant. In addition, her three-year marriage was adversely affected: she states her husband had been a "shining star in my dark world," but his patience "is wearing thin." Sexual desire dysfunction, isolation, avoidance, and numbing were sources of difficulty for the marriage. In the past three years her job performance had deteriorated: she almost lost her job on at least four occasions during this period. She now states that, unless she gets the proper assistance, "It's only a matter of time" before she loses her job and destroys her marriage.

The trauma-derived representations noted by the therapist during the course of the treatment were *rageful, violent "maniac"* and total environmental failure to rescue and protect, the *ineffectual authority*.

### *Case of Multiple Childhood Rape Episodes in an Adult*

Ms M is a 30-year-old woman who was born in the Midwest, raised in the Mid Atlantic States, and now lives in northeastern United States. She works as an assistant manager in a large corporation. She was raped at ages 8, 10, 12, and 16 by adolescent and young adult males known to members of her family. The patient remembers the terror she felt, the excruciating need to tell and the concomitant inner and outer pressure not to tell, but to maintain the awful silence about her ordeal. She spoke of the shame, guilt, and inability to put feelings into word for many years. Ms. M. knew these episodes had a profound impact on her life, but felt that as the years passed she would overcome her inner distress and general emotional disabilities. Ms. M. had a difficult childhood, and endured significant neglect, abandonment, and constant humiliation by both parents. Her mother was an alcoholic who "was always drunk, depressed, and pissed off." Her father was emotionally distant from the four children, but was known to take seriously his role as provider. He had three jobs, partly motivated to avoid the troublesome family atmosphere.

Ms. M's complaints during the assessment process included nightmares, depression, anxiety, panic attacks, self-denigration, low self-esteem, envy, rage, doubting, suspicious, and feelings of incompetence and unworthiness. Among the key representations explored in the treatment were the violent betrayer, and its relational opposite, ineffectual authority. In the later phase of the treatment these representations emerged for intense exploration and integration. The patient's hostile and dysphoric projections created the opportunity for understanding the original

traumatic relationships in the patient's life. The therapist was unconsciously perceived as both *betrayal/abuser* and *ineffectual authority*. Thus, the patient saw the therapist as "someone whose chief duty is to harm deeply," and as someone who was "nothing more than a drunken failure" in protecting her from abuse.

### *Case of Vehicular Accident Trauma*

Mr. E. is a 47-year-old man who sought therapy after suffering from traumatic stress symptoms for 8 years. "I thought I could handle these emotional problems alone; but I found the stress got up too high; I was out of control; and my problems kept getting worse and worse." His Honda had been slammed into on the passenger's side by a much heavier vehicle, a Dodge Dakota truck whose driver was drunk and had not heeded the red light to stop at the intersection. Mr. E's childhood friend was killed instantly. They were very close all their lives, and had new plans to build a business together. The patient was comatose for several days, and was not expected to live. He has three children, and suffers "dark times" with depression, outbursts of rage, low self esteem, self-blaming, avoidance, sexual dysfunction, and nightmares. He grew up in a stable family, and reports no history abuse or family psychiatric history. The *killer/victim* representation emerged as a core set of dynamics to be relationally processed in the therapy.

### *Representational Psychology and the Assessment Process*

The purpose of gathering data on trauma representational psychology is to construct a guide for the treatment enterprise, particularly for advanced-phase explorations and analyses. The various representation indicators derived from Rorschach variables and contents, and from aspects of the MMPI and MCMI are highlighted and reframed in therapeutic relational terms.

As a result of using the Rorschach, a clinician-administered clinical interview, and self-report tests, the clinician was able to collect preliminary data on possible representational processes for each patient. Representational images and dynamics often emerge with greater clarity over the course of the treatment. This allows the therapist to retain, discard, or modify initial impressions and conclusions about self- and other-representations. This writer recommends representational assessment in addition to the symptom assessments often done with brief PTSD scales and self-report instruments reported in the trauma literature.

Post-traumatic alterations in representations involve structural changes, with dramatic shifts in perception, cognition, emotion, and behavior. Wagner and Fine (1979) were cognizant of the utility of projective testing for identifying and understanding the nature of patients' representations in the clinical setting. The clinician may identify alterations in self-representation and other-representation on the Rorschach by examining the

Comprehensive System's Structural Summary (Exner, 1990) and identifying key content responses and scoring categories:

- Analysis of Contents
- Analysis of abrupt shifts in levels of organizational activity, form quality, and in developmental quality.
- Special Scores (analyzing contents associated with DV, DV2, INCOM, INCOM2, DR, DR2, FABCOM, FABCOM2, ALOG, and CONTAM).
- The Self Perception Section (examining contents associated with Fr + rF, FD, MOR, sum of An or X-ray, and the Egocentricity Index ( $3r + (2)/R$ )).
- The Interpersonal Section (Isolation Index—Isolate/R); interpersonal interests—H:(H) + Hd + (Hd).
- The Hypervigilance Index.
- The Affect Section (analyzing contents associated with FC:CF + C, Afr, and Blends/it).
- M and M-responses (examining the contents linked to these variables).

Alterations in self-representations and other-representations may be detected on the MMPI variables below.

- A high, elevated F Validity Scale indicate rarely endorsed items, reflecting profound subjective distress, "consistent with the wealth of unusual experiences [trauma] patients report" (Allen, 1995, p. 55).
- Analysis of individual items that measure persecution, hypervigilance, negative relationships, social detachment, and aggression. In general, specific items associated with the clinical scales, Pd, Mf, Pa, Pt, Sc, and Ma.
- Clinical examination of items specifically referring to persecution and to unusual experiences.

Alterations in self-representations and other-representations may be inferred through the following MCMI variables.

- Scales measuring unusual experiences.
- Indicators of negative relationships.

### **Dissociated Representations of Self and Other**

#### *Internalized Violence and Abuse-Related Representations*

The term "representations" refers to schemas of internalized action patterns (in Piaget's sense) consisting of developmental structures organ-

ized from bodily, mental, and relational experiences that offer the individual a sense of continuity and cohesion. Representations, as used in this article, are similar to Jacobson's (1964) definition, and to the contemporary meaning of "schema," as enduring, slow changing, organizing structures.

The shocking impact of *internalized* abuse, of armed force warzone savagery, political victimization, and of homicidal encounters, is intrapsychically organized as representations of the mind/body system. Though non-pathological forms of dissociation are common in the general population (Irvin, 1985; Ross et al., 1990), and may even serve adaptive ends for many, post-traumatic dissociated representations are organized to defend passionately against feelings of depersonalization and the sense of pervasive fragmentation.

Though diagnostically nonpsychotic, the dissociative defenses that accompany terror of death feelings resemble the *psychotic anxieties* reported by Margaret Little (1990) in her book on Winnicott and her own analysis. Dissociation, "the mind's flight from its identity moorings," represents an organized separation of thoughts, memories, emotions, identity, and mental functions separated into complexes that form an "autonomous *split-off* mental organization that functions at primitive levels ... hence the ... dissociated phenomena of flashbacks and other incursive automatic ideas and feelings" (Parson, 1984, p. 15).

Brende (1983) and Brende and Parson (1985) found these core dissociative self-representations to be integral to psychodynamic formulations on character pathology in traumatized veterans. They thus theorized a loss of self-identity, a dynamic alternation between idealization and devaluation (in interpersonal relationships), risk-taking behavior, outbursts of uncontrollable anger, sense of meaninglessness, and splits in the self to form the "killer self" and "victim-self" with associated pathological omnipotence.

### *Trauma-Distorted Representations of Self*

Developmentally, the self-representation matures sufficiently by two years of age, and is associated with the development of a behavioral memory system (the expression of memory via behavioral reenactments) and a verbal memory system (which predominates over behavioral memory after the child's fourth year). Self-representation refers to biopsychically structuralized ideas, feelings, actions, sensory, and somatic expressions about the self, time, and causality on conscious, preconscious, and unconscious levels and dimensions.

The clinical management of representations in traumatherapy is critical for the integration of narrative trauma memory (Brown, Schefflin, and Hammond, 1998; Parson, 1984, 1997). Thus in victims of sexual abuse a

key task of the treatment is not only memory processing and and deconditioning of negative affects, but also the integration of the "*internalized dissociated perpetrator self*."

Self-representations, as structures within the mind, consist of realistic and unrealistic views of self. As schemes, they are involved in active organization of past reactions. Trauma-organized representations contain memory fragments that fail to revise or update the autobiographical memory. They are related to emotional lability and impulsivity, poor capacity for introspective and symbolic thinking, and to impoverished sensitivity to nuances of interpersonal relationships. Self-representations, additionally, consist of central organizing beliefs pertaining to "I am" and to "who I am." After overwhelming events, victims find that their basic views and assumptions about self and the world (in terms of presumed goodness, safety, predictability, and the worthiness [of the self and others]) no longer sustain previous central organizing beliefs and perspectives. Each of the three patients in the studies above reported a sense of being in perpetual danger and of feeling fragile and vulnerable.

The self-representations of interest in trauma assessment are those which reflect trauma-influenced, distorted representations. Trauma self-representations occur as a consequence of the victim's internalization of trauma-linked images, relationships, attitudes, and violent and/or libidinalized impulses. Ms. M. and Ms. O. were particularly vulnerable to the internalizing of self-vengeance and violence. Sgroi (1989) and Parson (1994b) have noted that victims of violence and terror internalize pattern of self-violence. Violence- and terror-organized representations emerge in the treatment of many victims to be managed through the transference and countertransference spheres of the treatment relationship. Trauma self-representations are observed in a victim of political torture who saw on Card IV (whole blot), "A cruel, evil monster!", while a rape victim saw a "bloody ghoulsh attacker" on the same Card. On Card IV a veteran stated, "He's a big actor: you just can't trust this one!" Issues dealing with self-contempt, cynical rage, sadomasochistic enactments and self-abuse are also aspects of self-representations. A brutally traumatized rape victim who became suicidal, said, to Card VII: "This is a hooker: she was raped and she wants to kill!" A male sexual trauma victim responded to the same Card, "An irresistible sexual villain."

### *Trauma-Distorted Representations of Others*

In addition to the post-traumatic sequelae that distorts the victim's capacity for healthy self-perception are distortions in internalized images

of human relationships. Trauma create profound personality changes (Dorshav, 1978; Parson, 1997) which determine how the victim views self in relation to others. Thus, Ms. O., Ms. M., and Mr. E. revealed shame, guilt, low energy and depression, low self-esteem, and intense paranoid fears and distrust which interfered with establishing and maintaining trusting and meaningful human relationships. Relationship distortions become a key task of therapy, addressed chiefly through the relational dimensions of the treatment (between victim and therapist). Traumatic other-representations are internalizations consisting of encoded attitudes, perceptions, and evaluations about others acquired during and after the trauma (e.g., perpetrator/abuser and ineffectual protector/neglector representations). Thus, on the Rorschach Card III a guilt-ridden, hypervigilant crime victim perceived "Two slaves bowing down, but distrusting each other," while Ms. M. stated, "Two people lifting, but they are weak and helpless." Profound distrust may also be implied from Ms. O's response of "masked men with sinister intentions" to Card I.

Hypervigilance expands the space between self and others to defend against the awareness of passivity and vulnerability to anticipated attack. These feelings *will* emerge in the therapy and should be sensitively explored with the patient. Such fear-based representations and related avoidance and dissociative defenses interfere with the quality of victims' relational engagements. But exploring them in therapy may spark new integrative, developmental/maturational possibilities when explored and managed within the transference and countertransference spheres of bipersonal processing in therapy.

### TRAUMATHERAPY

In traumatherapy, specific techniques and procedures are geared to integrate dissociated fragments of the personality, and trauma-related representations. The first goal is to stabilize a shaken biopsychobehavioral system, one plagued by severe guilt feelings, depression, perceptual dissonance, suicidal dynamics, with increased peripheral autonomic nervous system activity, comorbid configurations, traumatic memories and repetition-dread, deficits in self-esteem regulation, and with traumatic defensive structure and identity. This stabilization is facilitated by *traumatic narrative memory processing*, which also deals with metaclinical issues pertaining to meaning, social, political, institutional, and ethical factors associated with the traumatic event (Brende & McCann, 1987; Brown & Fromm, 1986; Chu et al., 1996; Deering et al., 1996; Erikson, 1968; Ferrada-Noli, 1998; Fischman, 1998; Ornstein, 1974; Orr et al., 1998; Parson, 1988, 1993, 1997;



Weine et al., 1998). During this phase an important objective is to raise the memory-affect level of arousal that facilitates access of neurophysiological "fear structures" (Foe & Kozak, 1986).

The second general goal, the subject of this article, is to process relational aspects of the traumatic event. This is facilitated by later phase *bipersonal representational memory processing*, which involve in-treatment bipersonal dynamic relating and extratherapeutic relational analyses. As a consequence of the overwhelming event, *through the process of internalization, the victim/sufferer becomes the abuser, assailant, the enemy, torturer, or the neglecting, narcissistically-controlling, power-abusing authority*. The rape victim may thus internalize the attacker, and so become him (or her) in attitude, perception, and impulse-expression tendencies. These introjects or representations have controlling and regulatory functions, and are therefore core considerations to be explored *directly* in the therapy. This representational exploration cannot be left to chance alone.

Representations contain the victim's unconscious relational programs that originated in childhood and in other life cycle periods, and they reenact and motivate impulse-driven, self-destructive behaviors. They may also activate positive prosocial impulses to build and restore the lives and communities of victims. As post-traumatic learning structures, representations contain the nuclei for dissociative narcissistic insult-based rage (due to awareness of the violation of the self), affective turbulence, deep sense of vulnerability, and shattered identity. Inner-city multiply traumatized children and youths may thus internalize the violent gang banger, this introject propelling the child or youth into intense rage, desire for revenge, and suicidal preoccupations. The POW veteran internalizes his cruel interrogators, while the victim of political torture and organized violence internalizes human cruelty, and experiences a need for revenge.

The earlier phases of traumatherapy employed cognitive, behavioral, and regressive techniques like meditation, hypnosis, and abreaction (Brende & McCann, 1987, Brown, Schefflin, & Hammond, 1998; Parson, 1984, 1997). In the later phases, however, the tools for representational exploration and integration are the therapist's increased empathic attunement (with related cognitive and emotional components [Kohut, 1977]), optimal receptivity and responsiveness, and dynamics-sensitive intervening. The sense of safety, trust, and predictability are *prerequisites* for intensive representational analyses. It is the therapist's function as reliable *container* of traumatic anxiety (Mollon, 1993. Parson, 1984) which ultimately makes possible the working through of the "internal tormentor" representations (found in most trauma victims). Here the emphasis is on the process rather than on the contents of the patient's verbal material. The therapist contin-

ues to ensure therapeutic-environmental safety which facilitates remembering and trauma-processing.

In TrSPD therapy, the person of the therapist is as critical to outcome as the patient. The traumatic representations are progressively integrated through bipersonal relational processing in which personal boundaries separating patient and therapist are permeable. The therapist actively seeks data on the patient's perceptions, cognitions, and feelings as they relate to the person of the therapist. These data, which include dreams, nightmares, painting, drawings, and spontaneous associations, are used by the therapist to understand the patient's relational reenactments linked to traumatic internalizations.

### **The Bipersonal Relational Processing Unit: An Here-And-Now Emphasis**

The therapeutic relationship in traumatherapy is facilitated by a interfusing of patient-therapist elements that progresses attitudinally and technically from a patient-therapist duo to a bipersonal processing dynamic unit. The terror that attends the victim's reliving experience requires a close facilitating therapeutic relationship. Reflecting on the works of others and on their own extensive clinical experience with trauma victims, Ulman and Brothers (1989) concluded that an essential function of traumatherapy is to *"revive and reexperience dissociatively spit-off areas of self-experience within the transference as part of reconstructing and working through the unconscious meaning of trauma"* (p. 242, italics added).

The goal of the representational phase is to integrate a variety of personality dysfunctions associated with the traumatic representational memory system. The goal has a number of components: (1) structuring the patient-therapist duo into a bipersonal processing unit, (2) increasing victims' insight into perpetrator psychology; and (3) integrating the personality to serve as bridging structure traversing the traumatic past to an optimistic future of control and meaning.

Bipersonal processing refers to specific attitudinal, technical, and experiential procedures in traumatherapy in which the victim and the therapist engage in a meaningful mutuality, with an emphasis on the therapist's introspection, empathy, and technical intervening. Differing from mere therapist's transparency, this sharing mutuality is characterized by a back-and-forth flow of cognitive and emotional data between patient and therapist, a bipersonal processing experience, referred to by Atwood and Stolorow (1984) as the "intersubjective approach." Josephs' (1995) *relational character analysis*, a melding of one-person and two-person psycholo-

gies, is useful and indispensable in TrSPD treatment. His approach seeks to balance Kohut's "warm heartedness"—an empathic, soft, supportive, and emotional approach and Reich's "hard headedness"—a confrontational, hard, and intellectual approach.

Trauma treatment requires a balance of empathic and confrontational approaches in an environment of equal partners in which therapists verbally impart here-and-now formulations about their understanding of the patients' inner representational world—the distortions and related misperceptions, miscalculations, rage, and murderous internalized impulses. After the therapist delivers such summative nuggets of dynamic "truths" to the patient, Josephs states that "the patient is then free to confront, challenge, question, ponder, refute, refine, and/or assimilate the [therapist's] ... characterizations, be they flattering or unflattering" (p. xiii). In this bipersonal relationship the corrective/reparative strategy is to enhance the treatment environment so that "remembering, repeating, and working through" (Freud, 1914) in the here-and-now are possible for processing trauma-distorted personality representations.

Heinz Kohut's (1977) concepts of *selfobject*, *mirroring*, *idealization*, and *twinsip* are important in working with representational systems in traumatherapy. As the victim's selfobject? the therapist is experienced by the patient as an extension of self, and attempts to fulfill three basic needs of the victims; namely, to be experienced as special, to identify and own the advantage and power of an idealizable person, and to experience self as being similar to others to validate and affirm one's self as belonging. In traumatherapy, the therapist's willingness to reflect back the patient's deeply held ambitions, sense of greatness, and specialness enlarges the victim's sense of self. Mirroring provides replacements for specific deficits stemming from the victim-victimizer traumatic relationship, while enhancing the victim's capacity for empathy, tolerance, and respect for self and others.

The selfobject relationship bridges the gulf between the violent and nonviolent worlds, and facilitates the acquisition of new capabilities Kohut refers to as "transmuting internalizations." These are psychic structures that empower the victim to control persistent feelings of betrayal, degradation, humiliation, violation, and abandonment, fears, and dissociative defenses. The victim also needs the opportunity to use idealization in relation to the therapist. While the mirroring relationship reflects back the victim's sense of ambition and progressive strivings, the idealized relationship facilitates the patient's control and regulation over paranoid fears and distortions of others' motivations, intentions, and behavior. Idealization is the process of internalizing the ideals, ambitions, competence, and the therapist's positive and helping attitude. Idealization is understood here not as a defensive

operation but as a strategy for survival-enduring through the mental perils lurking in the dark chambers of dissociated representations. Through idealization the patients featured in the clinical vignettes were each able to gradually internalize goals, ideals, ambition, calmness, and a zest for life.

Group traumatherapy is also an important facilitating modality in representational traumatherapy. The group expands the victim's disclosure capacities and network through exposure to potentially healing selfobject, mirroring, idealizing, and twinship experiences in the group (Frick & Bogart, 1982; Frawley-O'Dea, 1997; Parson, 1984, 1985b, 1988b, 1993). In terms of group mirroring opportunities for female adult survivors of childhood sexual abuse, Frawley-O'Dea (1997) states that the group allow the patient to learn how to trust and respect her own mind and give up a "tenacious allegiance to an omnipotent, all-bad self-representation." She illustrates how the group's transference/countertransference matrix "permits members to enact, identify, and work through central internalized relational configurations." The therapist's objective is to "maintain transitionality, a focus on process, and the capacity for play" (p. 427).

### *Resistance and Avoidance in Bipersonal Processing*

The therapist sees the trauma patient's resistance as a protective shield against further traumatic encroachments in *any* relationship to include the one with the therapist. This writer prefers the term "resistance" to "avoidance" when the representational aspects of trauma treatment are discussed. Resistance suggest "processes and agencies" (Shapiro, 1996). It refers to the mostly unconscious dynamic relational drama that is characteristic of human-engineered trauma. Avoidance, on the other hand as used in common trauma clinical parlance, relates to mostly conscious maneuvers that increase feelings of security against intrusive concrete trauma-based stimuli, images, memories, affects, and enactment tendencies. Thus, while avoidance is a cold, affect-isolative maneuver against feeling the pangs of anxiety, resistance intentional attitude and purpose.

Resistance is here understood as a biologic tendency to hold onto the familiar, to prevent the surrender of personal power to the dread of being overwhelmed (once again), by both concrete trauma elements (i.e., reminders) and unconscious traumatic representational elements. Paul Ornstein's (1974) concept of "dread to repeat" is relevant here. Resistance tends to intercept anxiety-activation and physico-arousal associated with the threatening inducement to repeat dreaded traumatic memories and enactments.

Resistance is a counterbalancing device that puts subjective power back into the hands of the subjectively powerless. Resistance is seen by the therapist as an ally in working through of dissociative representational pathology.

### **Perpetrator Psychology as Indispensable Treatment Element**

The approach advanced here is a relational model of treatment organized to manage trauma-based relational dysfunctions (Parson, 1994b; Pearlman & Saakvitne, 1995). Representations of trauma-based relationships require that therapists understand *not only the victims' symptoms but also their victimizers' dynamics*. This notion is an unpopular one, because the victimization scenario is often dichotomized into an all-good/all-bad perceptual matrix. Often this dichotomous perception creates an emotionally-laden designation, "piteous victim/irredeemable villain." Both sides of this psychological split are aspects of the victim's representational world in need of therapeutic reconciling, processing, and integrating. For the therapist and victim to study and understand perpetrator psychology is not a gift to the victimizer; it's a gift for the victim. This position is not about sexual/gender politics; but it's about trauma treatment. This writer, like many others (e.g., Brown, Schefflin, & Hammond, 1998; Davies & Frawley, 1994; Parson, 1984; Salter, 1995), holds that therapists treating incest and rape victims (and other traumatized persons) are expected to master the treatment of offenders because trauma specialists often do not recognize the "internalized offender" (Salter, 1995). "Offender psychology" also describes the inner world and behavior of the agent of genocidal trauma. This psychology, as noted by Brown, Schefflin, and Hammond (1998), "*has relevance to victim treatment*" (p. 464; italics added). This writer holds that, in addition to offender psychology, the therapy participants must also attend to the ineffectual protector internalization—the mother, father, sibling, or close relative who failed to stop the abuse because of basic deficiency in caring or interest, lack of courage, persistent denial, or psychic compartmentalization.

Educating the patient about offender psychology and ineffectual protector dynamics are important aspects of traumatherapy, and should therefore not be disregarded in treatment. Offender psychology involve the dynamics and distorted cognitions offenders use to overcome their initial inhibitions against the impulse to offend and sustain the traumatically insulting behavior over time (Hartley, 1998; Ward et al., 1998). Understanding the mind and behavior of perpetrators sheds light on their distorted worldview in interpreting, explaining, and evaluating the victim's

and their own thinking, feelings, motivations, and behavior. More importantly, it sheds light on the victim's endopsychic experiences.

The understanding of offenders' and ineffectual protectors' cognitions, emotions, motivations, as well as their past and present life are important considerations. This is in part because the insight obtained gives victims a *dynamic mirror* into which they may look and see their own image reflected back—the other side of victimization; namely, aspects of the violent, sadistic dissociated perpetrator-self replete with fantasies and potential violence against people. This is the most difficult part of the treatment—seeing and experiencing the enemy within. This enemy within becomes the *enemy externalized* onto the image and person of the therapist. With this externalizing event, bipersonal processing is possible.

### **Personality Organization: Traversing Traumatic History, Stress Symptomatology, and Future Control**

#### *Narrative and Representational Memory Systems*

Going beyond symptoms and narrative traumatic memory to integration of the representational system, involve trust, the setting of firm limits, and managing self boundaries so they are permeable and amenable to representational communication between patient and therapist. Additionally, this increases the patient's capacity for delay of first impulse. It also involves increased capacity for using and creating relevant personal symbolization, for dealing with novelty, and for tolerance of strong affect and arousal. The treatment of choice for psychological trauma is a multiphasic, multiple technique (i.e., cognitive, behavioral, dynamic, and existential), and relational enterprise (Parson, 1994a, 1997, 1998). Generally, the treatment begins with a primary focus on external events and conscious contents of the narrative trauma memory system during the earlier phases, to a later progressive shift in awareness to the internal content (chiefly representational models) of the trauma experience in the later phases (Brown, Schefflin, & Hammond, 1998, p. 491; Parson, 1997, 1994b, 1988).

In trauma contexts, the patient's personality is obviously an important variable in the treatment. This is in part because personality is the self's identity—"anchoring" organization of here-and-now experience which facilitates vital reenactments, cognitive processing, and emotional working through of internalized relational pathology. Such anchoring action ensures a relatively stable organization of stress response process despite trauma-associated symptoms of intrusion, dysphoric affects, and physiological arousal. The "unconscious history of Vietnam in the group" (Parson, 1988)

is actually a contemporary scene in a new unit, replete with representations pertaining to dangerous and corrupt leadership, and to paranoidly fearful subordinates with “fragging” violent impulses on their minds to be unleashed upon the group leader in the transference.

The victim’s personality contains structures of identity which serve a *bridging function* that links the traumatizing past to the post-traumatic present and to a future of possible personal growth and contentment. Traumatic reliving and dissociative processes pressure the patient to respond with psychological regression, remaining fixated on the past while sustaining a pervasive blaming attitude that undermines personal responsibility and growth. This fixation on the past militates against the present, instigating a passionate avoidance of the here-and-now, while depressive feelings darken vistas of hope and possibilities for the future. Representational analysis is an here-and-now therapeutic venture. The therapist focuses the patient on here-and-now psychological phenomena, especially the transference and associated emotional components of malignant representations.

In terms of self- and other-representations originating in Vietnam’s warzone, Frick and Bogart (1982), two young psychiatrists, reported on a sudden and peculiar experience in which they countertransferentially intuited having been thrust into the unconscious role of dangerous, “green horn,” dispirited, naive, and incompetent leaders (“the lieutenants”). Group members’ split-off, dissociated representations instigated intense fears associated with going on yet another “mission” where lives could be lost.

Narrative traumatic memory is the chief focus of cognitive and behavioral therapeutic activities reported in the traumatherapy literature. But this focus is not enough: it achieves only one aspect of the integration process. Another dimension of autobiographical memory must also be engaged for full integration to occur. Brown, Schefflin, and Hammond (1998) and Davies and Frawley (1994) are correct when they state that narrative traumatic memory integration must be followed by integration of the representational system. Resolution of traumatic memories and related symptoms occurs in the earlier phases of the therapy; representational exploration and integration occurs in the later phases. The later phases are particularly concerned with the bipersonal restructuring of traumatic internalizations in which the person of the therapist is an indispensable variable in the treatment.

Stabilizing and integrating the victim’s personality organization helps the patient to heal from a painful traumatic history. The process of integration of narrative memory and representation memory is key to personality integration, and is facilitated by the therapy through the use of uncovering techniques, cognitive restructuring procedures, and relational explorations in which therapeutic arousal of strong affects and abreaction foster cognitive/perceptual change and personality integration energized by

the patient's "unconscious commitments" (Hammond in Brown, Schefflin, & Hammond, 1998).

*The Therapist as Target of Dissociated Perpetrator Aggression*

Emotional connectedness between patient and therapist is also a prerequisite for representational work. Having a history of being protected by the therapist from the ill-effects of narcissistic injuries in and outside of the therapy, the therapist gives the patient "permission" to express bottled-up rage and hate—not only toward perpetrators and ineffectual/nonprotecting authorities, but toward the therapist's self. These violent impulses are often associated with internalized aggression that experientially mirror the perpetrator's violence and cruelty, and the ineffectual protector's cold indifference.

To increase psychological survivability, some victims use intimidation and rage toward the therapist, others employ intense, harsh criticism. Thus, Mr. E expressed affective storms of accusations and protest: he felt the therapist was "too powerful." He, like Ms. O. and Ms. M., employed this emotional stance to preserve the integrity of the self. The therapist understood these behaviors as critical forms of communications geared to reduce feelings of fragmentation, guilt, and shame, while preserving and replenishing self-esteem. Rage and criticisms are also "techniques" victims use to deal with the "menacing power imbalance in the therapeutic relationship," and to reduce the threat of passivity, intense feelings of vulnerability, and repetition of the traumatic history. To help the patient process the trauma, interpretation of transference and countertransference responses is used to understand, clarify, and show acceptance of the patient's representations (of the internalized victimizer).

For representational integration to occur, the therapist understands the importance of being technically accessible as target for the patient's projections, sadism, masochism, and transference paradigms, to include maternal, paternal, fraternal, and peer transferences as these emerge during representational analyses and later integration work. The therapist is also aware that empathic failure caused angry attacks from Mr. E. whose need to punish himself (and related meanings) may not have been fully appreciated by the therapist at a given moment during a session. Rage was, for Mr. E., a normal response to a sense of empathic derailment on the part of the therapist. This response was addressed directly with a focus on the underlying motivations, meanings, and adaptive functions for the rage attack, explored within the bipersonal relationship. Whereas in earlier phases the therapist used cognitive and behavioral techniques to manage such re-



sponses, during the representational phase the therapist employed dynamic bipersonal processes to gain insight and behavior change.

### *Malignant Representations*

The patient and the therapist are confronted by *malignant* and *benevolent* representations. The *malignant representation* is the primary representation in dynamic traumatherapy. This is the representation that motivated Ms. O. during a latter phase session to state, "I am so confused: I was not only attacked by a vicious man, but I feel like the attacker too. I also want to slash, to kill!" This became a core dynamic therapeutic focus for the patient-therapist mutual relational processing. Without a therapeutic emphasis that confronted Mr. E's malignant representations, he would have persisted in a failed unconscious search for redemption from a harsh intrapsychic moral agency. This self-defeating search for inner peace derived in part from virulent guilt-driven defenses observed in his obsessional tendency to expand his 35-hour-per-week job to 70 hours, without overtime remuneration. Here, he paid the piper, as he neglected his physical health, and maintained distance from his family even on holidays when his family sat at the table ready to eat waiting for him to come home. When asked by his family why he was so late he told them to put aside selfishness and to try to place themselves in the shoes of the "underdog" and the "dispossessed." Mr. E. blamed himself for "killing my very special life-long friend," and went on to say, "I take full responsibility for it." Such representations were also seen clinically in guilt-ridden combat-traumatized veterans (Brende & Parson, 1985; Parson, 1988), in female adult survivors of childhood sexual abuse (Davies & Frawley, 1994; Frawley-O'Dea, 1997), and in violence-traumatized inner city children and youth (Parson, 1994b, 1995).

The benevolent representation is often not a focus in the therapy but it is important enough to be explored because it provides an essential balancing element, the positive side of traumatic stress. For Mr. E. benevolent representations were connected to a rescue specialist, the first and most memorable person he encountered immediately after the fatal crash. Mr. E. refers to this individual his "wondrous guardian angel that saved my life." This worker had stopped the bleeding, comforted him, and reassured him of survival despite his fears and anxiety, excessive blood loss, and excruciating physical pain and discomfort.

There are a number of paradigms for self- and other-representations. Some were mentioned above. Davies and Frawley (1994) outline four relational matrices they apply to sexually victimized patients. These are: "(1) the unseeing, uninvolved parent and the unseen, neglected child; (2) the

idealized, omnipotent rescuer and the entitled child; (3) the sadistic abuser and the helpless, impotently engaged victim; and (4) the seducer and the seduced" (p. 475). The authors correctly point out that each pole may be experienced by either the patient or therapist in the transference and countertransference. The specific path to relational analysis taken in any therapeutic relationship depends on the specific nature of the traumatic experience. The therapeutic permutations involving these relational matrices are many, and are activated to assist the patient integrate violent internalizations and move beyond the traumatic reliving response.

### *Dissociated Cyclical Relational Patterns*

The victim learns to change maladaptive patterns of relationships through a relationship with the therapist. Cyclical relational pathology in trauma victims is characterized by "disorganized attachment [which] shows extreme shifts between elements of anxious attachment, e.g., clinging, and elements of avoidant attachment, e.g., distancing. This 'cyclical' defensive style has been described as central to personality disorder like borderline relational dynamics" (Brown, Schefflin, & Hammond, 1998, p. 474). Additionally, this dysfunctional pattern of relating is linked to self-defeating and self-destructive tendencies which instigate treatment-subverting behaviors. This writer's experience shows that when representations are disavowed or ignored in therapy, the treatment fails to help the patient resolve self-defeating patterns and rectify a post-traumatic history of repetitive (circular) patterns of abusive relationships. This bipersonal mutuality facilitates the processing of "*dissociated relational pathology that is implicitly reenacted* [and] causally related to the trauma, e.g., chronic vulnerability to boundary-violating relationships and pathological dependency" (Brown, Schefflin, & Hammond, 1998, p. 476). This circular treadmill relating is a recurrent theme in dynamic therapy whose resolution is indispensable to recovery from a traumatic past.

### SUMMARY AND CONCLUSIONS

This article emphasized the importance of going beyond a symptoms-based approach to assessment and treatment to a representation-based approach. Representational analyses provide a clarity of central personality dynamics associated with *who* the victim has become by virtue of traumatic internalization. Borrowing Reich's therapeutic precept, Shapiro (1996) concluded that it is important to "Pay attention not only to the words but, also, to the speaker" (p. 9). This article thus discussed the importance of

making the inquiry into, "Who have you internalized as a consequence of the traumatic situation?" or "Which 'inner presence' abide within to account for the uncharacteristic violent ideation, impulsive action, and anti-pathic attitude you now experience?"

In non-traumatic situations consciousness is normally integrative: it's on the cutting edge of human experience. In post-traumatic personality functioning, however, conscious experience becomes fragmented, creating parallel (i.e., uncoordinated) consciousness in which dissociated self- and other-representations fail to revise or update the autobiographical memory system. One aspect of this failure to update autobiographical memory as time progresses is internalized terror. Metaphorically, traumatized victims' experience their inner world as a shark-infested sea of powerful, terror-driven affects and a concomitant absence of ameliorative cognitive regulation and control.

Generally, the article presented a perspective that is not so much concerned with *what* patients say (as in symptom-reporting) but with *how* they say it (as in expressions of character). The *how* was discussed as related to understanding post-traumatic personality configurations to which the therapist is always attuned. The perpetrator's thinking, feeling, and general personality style were seen as critical to outcome. The therapeutic bipersonal work increased the victims' capacity to tolerate strong affect, ambiguity, doubt, to bear anxiety, manage arousal, and to create positive cognitions and symbol-forming capabilities. Moreover, this increase in capacity can conceivably ameliorate persistent post-traumatic malaise, and psychic deadness akin to what Fairbairn (1952) called the "plate-glass feeling."

Specific interventions in the earlier phases of the treatment are geared to deal with acute responses such as suicidal ideation and behavior (Ferrada-Noli et al., 1998). Representational memory work, however, occurs in the later phases of the treatment when acute distress, suicidal temptations, and hyperarousal and intrusive ideation are under greater regulation. The objective of treatment was to integrate this memory system into the autobiographical system to achieve an harmonious and cohesive identity. The emphasis in this article was singularly relational. Three clinical vignettes were presented: in each treatment experience the core issues (aside from the predictable traumatic symptomatology) revolved around pathologized human relationships learned in the crucible of psychic traumatic disorganization. In relating to others they struggled with passionate relational extremes of being too close and dependent or being too distant and schizoidally isolated, evidence of significant attachment pathology.

Research data reveal that "*dissociated relational pathology that is implicitly reenacted* are causally related to the trauma, e.g., chronic vulnerability to boundary-violating relationships and pathological dependency"

(Brown, Schefflin, & Hammond, 1998, p. 476). In Ms. O's treatment, the therapist helped her to resolve intense rage, paranoid fears, and violent impulses typically expressed inappropriately toward others in both intimate and non-intimate relationships. She herself had become the "violent slasher," evidenced in her projectives, dreams, and in the transference relationship. Ms. M's choice of violent sexual partners and related internalized abuser representations were explored. In dreams and in transference responses the patient was able to gain insight and take action after intense explorations of her dependency, passivity, and "hidden evil side."

Brown, Schefflin, and Hammond (1998) hold that "abuser and failed protector self-representations [in incest, rape, and other victim/survivors] ... become activated ... as a consequence of shifts in defensive operations" (Brown, Schefflin, & Hammond, 1998, p. 490). Ms. O. felt anger over being betrayed so many times and by so many different individuals as she grew up. She saw the therapist as one who betrays and abuses, "just like those bad, dirty people." The transference also distorted the therapist's self to be failed protector. The power and force of the internalized abuser and inattentive protector made its way into the treatment where it was bipersonally processed in the transference.

The article also briefly discussed the importance of combining the use of the Rorschach and other projectives, standardized tests, and structured clinician-administered interviews to give the clinician a network of information relevant not only to the patient's symptomatology (and narrative traumatic memory), but also to his or her personality and associated representational systems.

Representations in therapy emerge from both the assessment process, and from the unfolding therapeutic dynamic process over time in which representations are identified, clarified, and analyzed to ultimately be integrated into the patient's identity system. Dealing with trauma representations was discussed as a core undertaking in the advanced phases of trauma treatment with the patients featured in the clinical vignettes. Transference and countertransference explorations are among the chief integration-facilitating measures.

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